HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 3 — 0 5

2. STATE: Nevada

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447

7. FEDERAL BUDGET IMPACT:
a. FFY 2004 $ None
b. FFY 2005 $ None

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19A, pages 21 through 25

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19A, pages 5a through 7.

10. SUBJECT OF AMENDMENT:
DSH Program

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Michael J. Willden

14. TITLE:
Director, DHR

15. DATE SUBMITTED:

16. RETURN TO:
John A. Liveratti, Chief
DHCFP/Medicaid
1100 East William Street, Suite 102
Carson City, Nevada 89701

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: JUN 23 2003

18. DATE APPROVED: MAR - 8 2004

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL - 1 2003

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Charlene Brown

22. TITLE: Deputy Director, CMSO

23. REMARKS:

FORM HCFA-179 (07-92)

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VIII. HOSPITALS SERVING LOW-INCOME PATIENTS
DISPROPORTIONATE SHARE HOSPITALS

A. Subject to the provisions of subparagraph 6, a hospital will qualify as disproportionate if it meets any of the conditions under subparagraphs 1 through 5.

1. A hospital's Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State.

2. The hospitals low income utilization is at least 25%. Low income utilization is the sum (expressed as a percentage) of the fractions, calculated as follows:

   a) Total Medicaid patient revenues paid to the hospital, plus the amount of the cash subsidies for patient service received directly from State and local governments in the cost reporting period, divided by the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the same cost reporting period; and,

   b) The total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources) in a cost reporting period, less the portion of any cash subsidies received directly from the state or local government, divided by the total amount of hospital charges for inpatient services in the hospital in the same period. The total inpatient hospital charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for Medicaid assistance under an approved Medicaid State plan), that is, reductions in charges given to other third party payors, such as HMOs, Medicare, or Blue Cross Blue Shield.

3. For public hospitals (i.e., hospitals owned or operated by a hospital district, county or other unit of local government), the hospital's Medicaid inpatient utilization rate is at least one percent.

4. For counties which do not have a public hospital, the hospital in the county which provided the greatest number of Medicaid inpatient days in the previous year.

5. A private hospital located in a county with a public hospital that has a Medicaid utilization rate greater than the average for all the hospitals receiving Medicaid payment in the State.

6. A hospital must:

   a.) have a Medicaid inpatient utilization rate not less than one percent,

   b.) have at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a

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State Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget) the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedure. This does not apply to a hospital in which:

i.) The inpatients are predominantly individuals under 18 years of age; or

ii) Does not offer non-emergency obstetric services as of December 21, 1987.

c.) not be an institution for mental disease or other mental health facility subject to the limitation on DSH expenditures under Section 4721 of the Balanced Budget Act of 1997.

7. Medicaid utilization rate means the total number of days of treatment of Medicaid patients, including patients who receive their Medicaid benefits through a health maintenance organization, divided by the total number of days of treatment of all patients during a fiscal year.

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B. Distribution Pools: Hospitals qualified under paragraph 'A' above will be grouped into distribution pools on the following basis:

1. Assuming total available DSH in a given fiscal year of $76,000,000, distribution pools are established as follows:

a) All public hospitals qualifying under paragraph A above and in counties whose population is 400,000 or more, the total annual disproportionate share payments are $66,650,000 plus 90% of the total amount distributed by the DHCFP in that fiscal year that exceeds $76,000,000.

b) All private hospitals qualifying under paragraph A above and in counties whose population is 400,000 or more, the total annual disproportionate share payments are $1,200,000 plus 2.5% of the total amount distributed by the DHCFP in that fiscal year that exceeds $76,000,000.

c) All private hospitals qualifying under paragraph A above and in counties whose population is 100,000 or more but less than 400,000, the total annual disproportionate share payments are $4,800,000 plus 2.5% of the total amount distributed by the DHCFP in that fiscal year that exceeds $76,000,000.

d) All public hospitals qualifying under paragraph A above and in counties whose population is less than 100,000, the total annual disproportionate share payments are $900,000 plus 2.5% of the total amount distributed by the DHCFP in that fiscal year that exceeds $76,000,000.

e) All private hospitals qualifying under paragraph A above and in counties whose population is less than 100,000, the total annual disproportionate share payments are $2,450,000 plus 2.5% of the total amount distributed by the DHCFP in that fiscal year that exceeds $76,000,000.

2. In no circumstances may the total amount of distributions to hospitals within distribution pools noted in 1. above exceed the total uncompensated costs for those facilities.

3. Uncompensated costs are determined by the sum of the cost for providing services to inpatient and outpatient Medicaid and uninsured patients less Medicaid payments (excluding disproportionate share payments) and any patient paid or third party paid amounts. (Third party amounts exclude any payments made by a State or locality to a hospital for services provided to indigent patients.) An "uninsured patient" is defined as an individual for whom services received by the patient are not covered by insurance, whether this coverage is medical or liability based coverage. Patient paid and third party paid amounts are based on the historical collection experience of the hospital for uninsured accounts or actual collections in the fiscal year, whichever is greater. A system must be maintained by the hospitals to match revenues on Medicaid and uninsured patient accounts to the actual billed charges of the accounts in the same fiscal year. Costs for Medicaid and uninsured patients will be based upon the methodology used for a HCFA 2552 report. Revenue will be deducted from cost. The total costs on the report will be subject to an independent audit, which must be submitted within six months of the hospital's fiscal year end.

C. *Hospital Base Payments*

1. Based on a study of hospital uncompensated costs completed in SFY2003, certain hospitals qualifying for DSH under paragraph A and subject to the limitations in paragraph B above,

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will receive the following annual DSH payments:

a)	University Medical Center of Southern Nevada	$66,531,729
b)	Washoe Medical Center	$ 4,800,000
c)	Carson-Tahoe Hospital	$ 1,000,000
d)	Northeastern Nevada Regional Hospital	$ 500,000
e)	Churchill Community Hospital	$ 500,000
f)	Humboldt General Hospital	$ 215,109
g)	William Bee Ririe Hospital	$ 204,001
h)	Mt. Grant General Hospital	$ 195,838
i)	South Lyon Medical Center	$ 174,417
j)	Nye Regional Medical Center	$ 115,000

2. The successor interest in the hospitals in subparagraph 1 above will receive these base payments so long as the facility continues to meet DSH criteria defined in this plan.

3. In no circumstances may the total amount of distributions to hospitals within distribution pools noted in 1. above exceed the total uncompensated costs for those facilities.

D. Distributions within Pools - Total available DSH is distributed to hospitals qualifying under paragraph A above within the pools described in paragraph B above on the following basis:

1. To the extent they do not exceed the pools established in paragraph B above, all base payments established in paragraph C above are made.

2. Any amount set forth in paragraph B above after all distributions under paragraph C will be distributed to the hospital within each pool with the highest uncompensated care percentage or the amount necessary to reduce the uncompensated care percentage of that hospital in the same pool with the second highest uncompensated care percentage.

3. Any amount remaining within a pool after the distributions described in subparagraphs a) and b) will be distributed to the two hospitals within the pool with the highest uncompensated care percentage or the amount necessary to reduce their uncompensated care percentages to that of the hospital in the same pool with the third highest uncompensated care percentage. This process continues until all funds within a distribution pool are distributed.

4. As used in this section, uncompensated care percentage is defined as the total uncompensated costs of a hospital divided by the total revenue for that hospital.

E. Proportional Reductions - In the event the total available DSH in a given state fiscal year is less than the amount described in paragraph B above, the following reductions will be made:

1. The amount of the distribution pools described in paragraph B above will be reduced by the same percentage as the percentage change from $76,000,000 to total available DSH.

2. To the extend the total base payments described in paragraph C above exceed their respective pools described in subparagraph 1 above, the base payments will be reduced by the same percentage as the percentage change from $76,000,000 to the total available DSH

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or until the total base payments within a pool are equal to that pool.